NATIONAL MULTIPLE SCLEROSIS SOCIETY

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Clinical Bulletin
Information for Health Professionals

Bowel Management in Multiple Sclerosis

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Bowel dysfunction is common in multiple sclerosis (MS), with symptoms reported by approximately 60% of those with the disease. Both constipation and involuntary bowel movements may occur, with constipation being by far the more frequent complaint.

MANAGEMENT OF CONSTIPATION

Constipation can be reduced by a stepwise process beginning with a search for possible iatrogenic factors (side effects of medications) and assessment for the presence of neurogenic bladder dysfunction, followed by progression through: a) basic natural measures relating to fluid and dietary intake, b) mechanical techniques such as digital stimulation and enemas, and c) medical interventions if necessary (see Algorithm A). In order to permit a true evaluation of effectiveness, sufficient time (up to four weeks) should be allowed for each of the regimens before moving to the next step . More extreme surgical procedures, which are indicated in rare cases, should be addressed by a gastroenterologist.

Medication Review

Several categories of medication can precipitate or exacerbate constipation, and a review of medications should be the first step in evaluating constipation.

- Antihypertensives
- Analgesics/narcotics
- Tricylic antidepressants
- Antacids
- Iron supplements
- Anticholinergics
- Sedatives/tranquilizers
- Some antibiotics
- Diuretics

Bladder Management and Fluid Intake

If bowel and bladder dysfunction are occurring in tandem, bladder problems should generally be addressed first. Many patients practice fluid restriction in an attempt to control distressing urinary symptoms such as frequency, urgency and incontinence. Once urinary dysfunction is no longer a major problem, it will be possible to work with the patient to increase fluid intake in order to prevent desiccated stool, which is difficult to move along the gastrointestinal (GI) tract and evacuate. The generally recommended fluid intake is 2000 ml/day.

Diet-Fiber, Bulk Formers, and Concentrated Sugar Preparations

In addition to fluids, prune juice and/or dried fruits are the easiest, and often most effective dietary measures. Sufficient dietary fiber is also essential. If a high fiber diet cannot be achieved, bulk supplements such as Metamucil®, FiberCon®, Perdiem®, or Citrucel® can be used. One or two glasses of clear fluid (e.g., water, apple juice, broth, tea) should be taken with these agents for full benefit.

Liquid sugar concentrates are another natural intervention. They act by drawing water into the intestine, thereby softening the stool. Preparations include Sorbitol®, Lactulose®, and Golytely®. Side effects are rare, and these agents are useful for long-term management.

Behavioral Interventions

- Educate to promote adherence to whatever plan is developed.
- Initiate and maintain a regular program of physical exercise.
- Schedule a regular time for evacuation that takes advantage of the gastrocolic reflex 20–30 minutes after meals, especially breakfast.
- Integrate the planning with the person's life style and cultural mores.

Oral Agents

A variety of oral agents facilitate the passage of stool through the GI tract:

- Colace® (docusate 100 mg)
- Surfak® (docusate 240 mg)
- Peri-Colace® (docusate and casanthranol)
- Phillips' Milk of Magnesia®

Suppositories

- Glycerin suppository to lubricate the stool
- Bisacodyl suppository to chemically stimulate the rectum to evacuate stool

The patient or caregiver must be instructed to insert the suppository against the rectal wall and not into the stool.

Enemas

Most useful is the Enemeez® Mini-Enema (a stool softening laxative). Fleet® or tap water enemas should be reserved for episodic use.

INVOLUNTARY BOWEL/FECAL INCONTINENCE: CAUSES AND MANAGEMENT

Involuntary bowel or fecal incontinence can result from several pathologic situations: sphincter dysfunction, constipation with rectal overload and overflow, and/or diminished rectal sensation. Fecal incontinence is often associated with constipation. Constipation distends the rectum and interferes with compliance. Therefore, much of the management of involuntary bowel is similar to that for constipation. However, there are factors to consider first when fecal incontinence is reported (see Algorithm B).

Dietary irritants such as caffeine and alcohol should be considered as contributing factors, and eliminated when present. In addition, medications that reduce spasticity in striated muscle (primarily baclofen and tizanidine) may be contributing to the problem and their dose or scheduling may need to be adjusted.

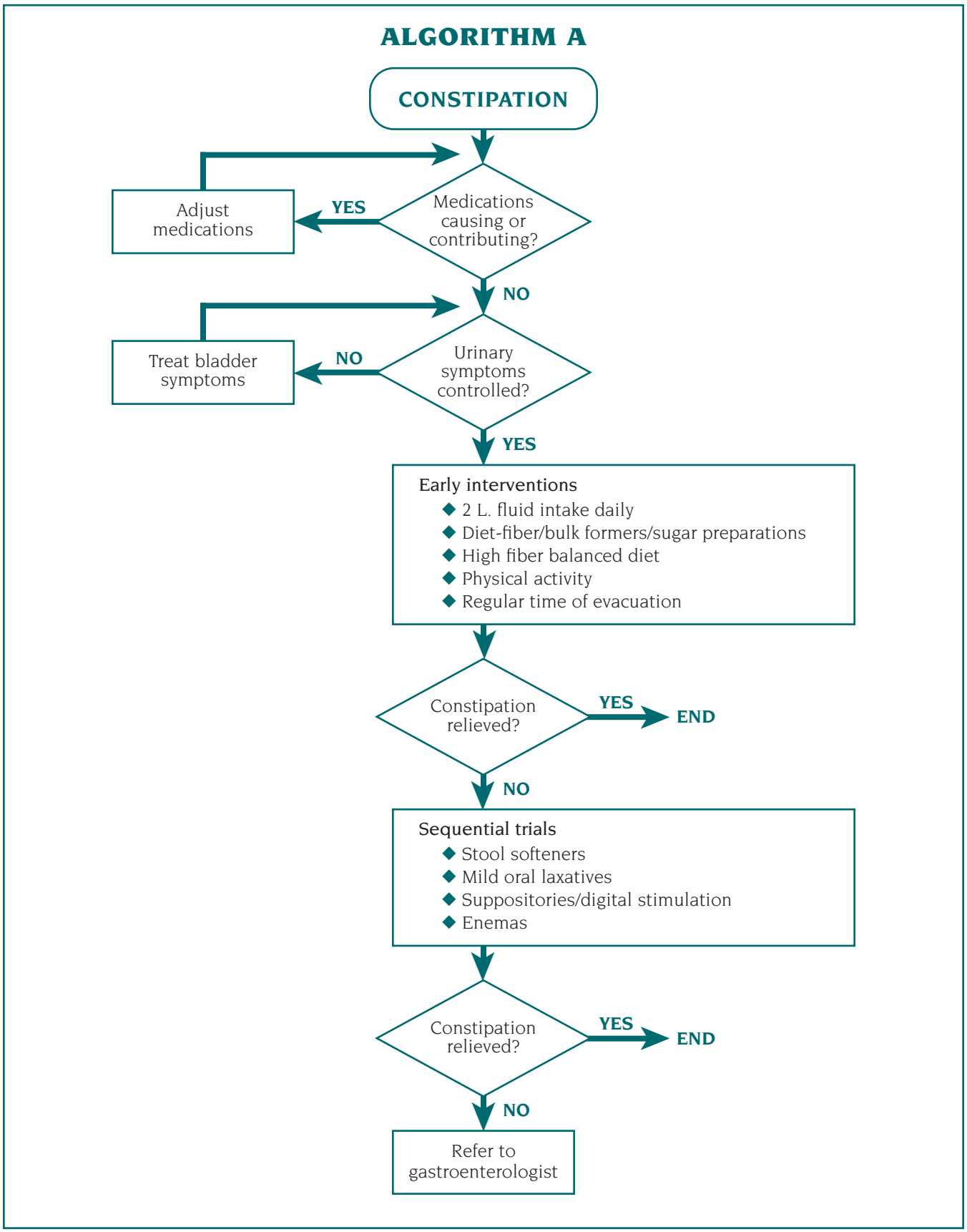
Anticholinergic drugs can be helpful when a hyperactive bowel is the underlying cause of incontinence. Since these drugs also affect bladder function, careful initiation and titration are needed, and post-void residual urine volume should be monitored to avoid precipitating urinary retention.

Diarrhea may lead to bowel incontinence, since it is difficult for the sphincter to contain liquid stool. The cause of the diarrhea needs to be identified. Impaction is a common component, with viral and bacterial causes also possible.

SUMMARY

Most instances of constipation and involuntary bowel in MS can be managed with systematic persistence on the part of both the patient and clinician. It is important to remember that bowel dysfunction, like other MS symptoms, can change over time, and that referral to a gastroenterologist is appropriate when conservative measures have been unsuccessful.

See Bowel Algorithms A and B on the following pages


ALGORITHM A
CONSTIPATION
Medications causing or contributing?
YES
Adjust medications
NO
Urinary symptoms controlled?
NO
Treat bladder symptoms
YES
Early interventions
2 L. fluid intake daily
Diet-fiber/bulk formers/sugar preparations
High fiber balanced diet
Physical activity
Regular time of evacuation
Constipation relieved?
YES
END
NO
Sequential trials
Stool softeners
Mild oral laxatives
Suppositories/digital stimulation
Enemas
Constipation relieved?
YES
END
NO
Refer to gastroenterologist

ALGORITHM B